FORT WORTH MEDICAL SPECIALISTS
724 Pennsylvania Avenue
Fort Worth, TX 76104
Phone: (817) 336-1200 Fax: (817) 338-4707

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This form must be completely filled out in order to process the request

Patient Name:_____ DOB:_____
Address:_____
Phone:_____
Reason for release:_____
Date Requested:_____ Date Needed:_____

Released From:

Name/Facility:_____
Address:_____
City/State/Zip:_____
Phone:_____ Fax:_____

Released To:

Name/Facility:_____
Address:_____
City/State/Zip:_____
Phone:_____ Fax:_____

□ Medical Record from (insert date) _____ to (insert date)_____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Representative: _____ Date:_____